Ensuring Stability and Access for Pharmacy:
Taxpayers and Patients Deserve to Know the Truth

SB2790 – Senator David Koehler

Background: In May 2023, the Auditor General released the *Performance Audit of the Administration of Pharmacy Benefit Managers*. This Performance Audit was the result of passage of SR 792 in 2022. The performance audit of the Medicaid Managed Care PBMs **identified over $200 Million over 2 years in spread pricing overbilling** to the Medicaid Managed Care (MMC) prescription program. Additionally, the performance audit identified that there was an undetermined amount of prescription overbilling where PBMs paid themselves more than were paid to non-PBM affiliated network pharmacies. The report recommended several contract reforms for HFS to institute in its MCO contracts to eliminate these abuses.

> "There is **little monitoring being done of the PBMs by HFS.** HFS did not have complete copies of contracts between the MCOs and the PBMs necessary to conduct monitoring of the contract provisions. **HFS also does not monitor contracts between the PBMs and the pharmacies** and, as such, is **unaware of the rates paid to the pharmacies by the PBMs**. **There is no verification being conducted to ensure that the reimbursements to PBMs by MCOs are accurate and reflect the actual payments paid to the pharmacies**. In addition, **HFS does not monitor actual reimbursement rates or rebates**. The entire monitoring function of the rates paid to pharmacies by PBMs is limited and based on self-reported, unaudited encounter data. As a result, **HFS was unable to provide support for adequate monitoring of the PBMs."** – From the Key Findings, *Performance Audit of the Administration of Pharmacy Benefit Managers* (emphasis added)

SB2790 will provide a fair and transparent platform to ensure pharmacy sustainability and preserving patient access.

- **Protecting our communities from becoming a Pharmacy Desert** by providing parity to the reimbursement for both Fee-for-service and MCO parts of Medicaid and establishing the same reimbursement and professional dispensing rates.
- **Ensures that MCOs and PBMs** must reimburse pharmacies at the Fee-for-service rates and not issue any additional fees to lower the reimbursement below Fee-for-service levels.
- **Clarifies determination of Critical Access Pharmacies** to ensure that critical access pharmacies in counties of 50,000 residents are eligible for the enhanced professional dispensing fee that critical access pharmacies in counties of less than 50,000 residents receive.
- **Ensures Accountability and Oversight** by providing data and information to the Department of Healthcare and Family Services to open transparency on how patient, plan sponsor, and taxpayers monies are distributed through the claim process.

ILPhA The Voice for Pharmacy in Illinois℠

Vote Yes for SB2790!

ICHP

Digest Exhibit 4
PAYMENTS TO PHARMACY BENEFIT MANAGERS
Calendar Year 2020 and Calendar Year 2021

CALENDAR YEAR 2020			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	Envolve Pharmacy Solutions	$358,000,000	$335,700,000
Aetna	CVS Caremark	27,700,000	26,400,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	500,300,000	484,900,000
CountyCare	MedImpact	378,500,000	362,900,000
Meridian Health	MeridianRX	705,100,000	640,000,000
Meridian YouthCare	Envolve Pharmacy Solutions	18,300,000	15,900,000
Molina	CVS Caremark	200,500,000	199,700,000
NextLevel	Envolve Pharmacy Solutions	13,500,000	13,500,000
CY20 Totals		**$2,201,900,000**	**$2,079,000,000**
CALENDAR YEAR 2021			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	CVS Caremark	$434,900,000	$418,100,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	625,800,000	606,500,000
CountyCare	MedImpact	457,800,000	445,200,000
Meridian Health	MeridianRX	789,900,000	757,700,000
Meridian YouthCare	Envolve Pharmacy Solutions	30,600,000	28,400,000
Molina	CVS Caremark	296,600,000	291,400,000
CY21 Totals		**$2,635,600,000**	**$2,547,300,000**

Note: Limitations noted by Milliman: "*Milliman has developed certain models to estimate the values included in this correspondence. The purpose of the models is to evaluate the health plan reported financial data. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose. The models rely on data and information as input to the models. We have relied upon certain data and information provided by HFS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. Milliman's data and information reliance includes MCO-reported eligibility and financial experience, as well as information related to HFS' eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.*"

Source: Evaluated by Milliman, and provided by the Department of Healthcare and Family Services.

Summary of Report

Full Report